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TITLE PAGE

Public health practitioners' views of the 'Making Every Contact Count' initiative and standards for its evaluation

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Abstract

Background. National Health Service [NHS] England encourages staff to use everyday interactions with patients to discuss healthy lifestyle changes as part of the 'Making Every Contact Count' [MECC] approach. Although healthcare, government and public health organisations are now expected to adopt this approach, evidence is lacking about how MECC is currently implemented in practice. This study explored the views and experiences of those involved in designing, delivering and evaluating MECC.

Methods. We conducted a qualitative study using semi-structured interviews with 13 public health practitioners with a range of roles in implementing MECC across England. Interviews were conducted via telephone, transcribed verbatim and analysed using an inductive thematic approach.

Results. Four key themes emerged identifying factors accounting for variations in MECC implementation: (i) 'Design, quality and breadth of training', (ii) 'Outcomes attended to and measured', (iii) 'Engagement levels of trainees and trainers' and (iv) 'System-level influences'.

Conclusions. MECC is considered a valuable public health approach but because organisations interpret MECC differently, staff training varied in nature. Practitioners thought that implementation could be improved, and an evidence-base underpinning MECC developed, by sharing experiences more widely, introducing some elements of standardisation to staff training and finding better methods for assessing meaningful outcomes.

Introduction

Non-communicable diseases contribute to around 63% (36 million) of the world's deaths annually[1]. Given their close links with behavioural risk factors they are often amenable to change (e.g. smoking, excess alcohol consumption, physical inactivity, poor diet)[2]. Ill-health from these behaviours confers National Health Service (NHS) spending of £18.4 billion annually[3] so helping people to change behaviours has become an increasing feature of health professionals' roles, as specified within the NHS England's Making Every Contact Count (MECC) initiative[4].

MECC encourages staff to use their everyday interactions with individuals to discuss healthy behavioural changes and is expected to be adopted by all NHS England organisations and partner organisations such as local authorities[5-7]. However, previous research has demonstrated that this is challenging for staff who can feel unskilled and find behaviour change discussions uncomfortable, daunting and even futile[8-10]. Although some research has indicated that staff training could enhance behaviour change skills in practice[11]. There is a paucity of evidence that identifies effective methods of design for MECC staff training programmes and how MECC implementation affects staff behaviours.

Supporting individuals in behavioural changes is important but complex, thus it is necessary to understand how organisations are currently implementing MECC, and the extent of their success. This study aimed to explore the views and experiences of public health practitioners (PHPs) – defined as public health leads in provider organisations with direct involvement in designing, delivering and/or evaluating MECC.

Method

Design

Qualitative study using semi-structured interviews with PHPs within England-based organisations.

Recruitment and procedure

Purposive sampling was used to recruit PHPs involved in the design, delivery, or evaluation of MECC in their organisation. Maximum variation for the following characteristics was sought: age; sex; organisation region, size and setting; job type, and length in current post. All members of a national public health provider network were emailed with study invitations. Snowball sampling[12] reached other eligible individuals not members of this network. Individuals interested in participating were provided with research team contact details to discuss their involvement and provide informed consent prior to interviews. Ethical approval was obtained from the University of Liverpool Research Ethics Committee (Ref: 1479).

Interviews were conducted by one researcher (AC) via telephone due to the wide geographical spread of participants. The interview topic guide explored participants' views of MECC and experiences of implementing it within their organisation (see Table 1). Interviews were flexible and unique to the participant via open questions eliciting free responses followed by more focused questions using probing and prompting. Interviews were audio-recorded and transcribed verbatim at which point any identifying information (e.g. names and places) were removed.

[Table 1 here]

Analysis

An inductive thematic analysis was conducted[13] whereby two researchers (PAC & AC) independently reviewed the transcripts and coded data patterns relating to the research objective. No pre-existing structure or framework was used to code the data. Regular meetings to compare coding between researchers enabled ambiguities to be resolved and led to the emergence of core themes and sub-themes. Analysis ceased when the themes encompassed all relevant data. NVivo 10 (QSR International Pty Ltd.) was used to organise and manage the data.

Results

Participant characteristics

Thirteen PHPs completed an interview between January and June 2017. Interviews lasted between 31 and 53 minutes (Mean=39 minutes; SD=6.95), ages were between 31 and 59 years old (Mean=49.5 years; SD=9.12), five (38.5%) were male, and eight (61.5%) female. Participants had been in their current post for an average duration of 5 years (SD=5.53; Range=1 month–18 years). Additional characteristics regarding participants' occupational context and setting are displayed within Table 2.

[Table 2 here]

Four key themes accounted for participants' views and experiences of MECC implementation: 'Design, quality and breadth of training', 'Outcomes attended to and measured', 'Engagement levels of trainees and trainers' and 'System-level influences'. Themes are described below and illustrated using verbatim participant quotes.

(1) Design, quality and breadth of training

Participants described different stages of implementing MECC workforce training. Some organisations used existing training programmes for staff, others were designing bespoke programmes, and some were evaluating previous training. Though they believed staff should receive MECC training with it being valuable to public health, many expressed concerns that previous efforts had dwindled due to lack a of momentum or commissioning difficulties, and were no longer running as initially intended.

> *I think a lot of the work we developed is probably now kind of not happening as well as it ought to be. (Participant_06)*

MECC programme content differed greatly between participant organisations. Some concentrated on one specific lifestyle behaviour (e.g. smoking) whilst others advocated a broad approach covering as many behaviours as possible. Rationales for narrow topic selection included because it either fitted with trainers' expertise (e.g. drugs & alcohol services background), or a current policy in the organisation (e.g. going 'smoke-free'),

attending to factors driving organisational costs, or needing to work from quality evidence bases.

> *Obesity, and drugs and alcohol tend to be the things that cause the most money to be spent [in our organisation]…So that's probably where we're going to lean a lot of our information to. (Participant_11)*

> *The evidence based brief intervention for obesity is very poor, so it, it was going to come down to alcohol or, tobacco, or both, or a small proportion of those. So it was, it wasn't difficult. I mean it's fairly obvious that smoking's the best evidence base. (Participant_02)*

Participants disagreed over the impact of content breadth on training. Some believed covering many topics increased the relevance of training to more staff, or would more accurately target existing determinants of health. Others felt breadth prevented constructive conversations with patients.

> *We took the decision that asking everybody about everything every time you saw them was pointless and hacked everybody off and didn't work, and we weren't going to do that. (Participant_02)*

Participants also disagreed on the best delivery method for MECC training staff. Some emphasised the benefits of online training; including the efficient use of resources and time. Others thought the complexities of the subject meant face-to-face delivery was necessary. Interestingly, most participants believed MECC staff training should be made mandatory to demonstrate the organisation's commitment to MECC; and would help achieve training targets. However, participants were aware that mandatory training doesn't necessarily translate to changes in clinical practice.

> *I think if you force somebody to attend a training (a) they don't pay very much attention and (b) it's probably not gonna, they're not gonna change their behaviour. (Participant_11)*

Participants broadly agreed that MECC training would be enhanced by some standardisation that was built on evidence with demonstrated efficacy. This would reduce ambiguity over MECC's aims (e.g. to raise staff awareness of health risk factors, encourage staff to raise topics with service users, or provide staff with behaviour change skills). Nevertheless retaining some flexibility over the content was important for organisations to allow it to be tailored to the local context.

> *Everyone wants their own local flavour on whatever there is but it is helpful to have tools, methods, whatever, that a Trust, or any organisation, can go to that, has done some of the work for them. So they're not starting from the basics. It would be good to have standardised, to have perhaps even evidence-based training that we know works that improves outcomes. (Participant_05)*

(2) Outcomes attended to and measured

Participants revealed that outcomes currently evaluated mostly related to training delivery, reporting on: staff attendance levels, satisfaction with training, and awareness of MECC and common health risk factors (e.g. smoking, obesity, alcohol). Participants were interested in evaluating the application of training to practice but attempts to measure this via post-training feedback was described as difficult due to large staff numbers, or people not having the time to complete evaluation forms. Other methods of assessing MECC training delivery were therefore through more sporadic verbal or written feedback. Participants argued that the ideal way to meaningfully evaluate training was to assess if staff training changed patient health behaviour or relevant health outcomes. However this was viewed as impractical. Participants thought that this would be unnecessary if there was sufficient evidence that using behaviour change approaches benefitted health outcomes. Many questioned whether this link had been clearly established.

> *I mean ultimately [MECC should be assessed] by the outcome it achieves in terms of prevalence and incidence of the various lifestyle and risk factor things you're trying to*

change. But in terms of, assuming there is an evidence base for that, then I think you can measure process. (Participant_02)

Aside from assessing efficacy, a benefit of measuring patient outcomes was to provide participants with positive feedback from using the MECC approach.

Clinicians need to see that they're, what they're inputting has made that difference because, you know, with any clinician, if you're expending energy on having difficult conversations with people but then you never find out whether it worked (Participant_08)

More feasible and therefore commonly measured was patient referrals to specialist services. This was viewed as a proxy measure of the impact of training that was a meaningful way of assessing the success of MECC training, and which also enabled feedback directly to staff.

We've also provided awards based on numbers of referral, and congratulated individual members of staff…our most concrete way of measuring impact is the number of referrals made for specialist help (Participant_12)

Participants also hoped that MECC training would benefit staff's own health though they saw this as another level of complexity. Although rarely included in evaluations, where this was assessed, it was measured via subjective feedback. Participants had seen evidence that staff had positive intentions to change their own behaviours, though for others benefits to their own health behaviours were not observed.

On the initial evaluation it seems that they come away from it feeling that they're ready to go and deliver support in their roles to people but not necessarily change their behaviour…changing your own behaviour might seem more difficult than trying to help somebody else to change (Participant_13)

Participants wanted to conduct long-term follow-ups to measure the impact of MECC within the organisation but questioned the feasibility of this in terms of the complexity of doing so coupled with the time needed to achieve meaningful organisational change.

(3) Engagement levels of trainees and trainers

Participants indicated that staff engagement in MECC was essential to training success. It was thought staff training would not translate to changes in practice unless staff believed in the advantages of the MECC approach.

> *I think once you've, once you understand where you fit in, where it would fit into your role, that's where you'll, you'll be more likely to want to do it. (Participant_11)*

There was a general consensus that staff at all levels were becoming increasingly supportive of the MECC approach due to increased awareness of the value of illness prevention. Where previous MECC training may have '*fizzled out*' (participant_04), participants believed that new policies and guidelines such as the NHS's 5-year forward view enhanced this awareness and would be more protective of revitalised or novel training programmes. Thus participants were largely optimistic that engagement in MECC training was growing.

> *I do think people are starting to understand that more, and certainly the directors and the clinicians I've spoken to can really see the value of prevention work. (Participant_01)*

Participants praised advocates and champions of the MECC approach within organisations seeing them as key to its development and continued implementation. It was suggested that without actively positioning people with a passion for MECC training to drive it forward, the less supportive individuals could jeopardise implementation efforts.

> *We've got champions and actually both amongst patients and staff there's a lot of support for this, but there's, especially with, in our situation there's a vociferous minority of about five per cent who hate it and do their best, and do, and do their absolute best to, to sabotage it, and we have to work around that. (Participant_02)*

(4) System-level influences

Participants described that despite a growing interest in MECC they faced barriers to its implementation from the wider systems and contexts, which ultimately influenced their ability to run staff training. Barriers often related to a lack of resources (e.g. staffing of trainers), money (e.g. for training materials), or decommissioning of whole programmes.

> *We're not delivering that intensive programme anymore, and it's a pity because it was absolutely brilliant, but you can only deliver what you're commissioned to deliver unfortunately (Participant_03)*

Some viewed barriers resulting from difficulties in committing to a MECC approach whilst managing acute current rates of illness within health care. There was tension between the desired approach to reduce illness through prevention and health promotion, and the existing system that relies upon managing illness reactively.

> *It's like flipping the whole thing on its head. And, you know, it's a national illness service, not a national health service. (Participant_05)*

As well as these broad system-level influences, participants identified that organisational culture hindered MECC implementation. Participants described hope of integration of the MECC approach within staff culture so it wasn't viewed as an add-on, and that systems would be developed so that when staff used MECC in practice, that they would have supporting infrastructure within their job roles.

> *I was training lots and lots of staff, thousands of staff in MECC but what was happening is the actual organisation wasn't embedding it in the current clinical regimes and pathways so in essence I was training them to do MECC but every time they went back on the wards they weren't, no they weren't, well they couldn't because it wasn't in the clinical pathway on the actual wards. (Participant_06)*

As well as describing training programmes as disjointed from practice, participants also described being unaware of what other organisations were doing to implement MECC. Communication between organisations about MECC training design, development or evaluation was limited and most felt they tended to operate in isolation from other organisations. They felt that this knowledge would be extremely useful in order to compare and improve their training but were unsure of how to gather this information. Lack of communication between organisations also worried participants that provider organisations were interpreting MECC differently in relation to training content. Some subsequently expressed doubts over the quality and consistency of their efforts compared to others.

> *I don't know [how our training differs to others]…My guess is it does differ quite a lot, because from what I know MECC training it's much broader, it brings in many more lifestyle issues and um, is perhaps more thorough that what we're doing. (Participant_12)*

Discussion

Main findings

MECC is considered a valuable approach with potential benefits for patients' and staffs' behaviours and health. Training was however viewed as patchy, with previous programmes being vulnerable to dwindling if enthusiasm and resources were not maintained. It was clear that staff are receiving different expertise from training programmes because PHPs interpreted MECC differently, having individual rationales and methods for selecting training content. Being unaware of how other organisations make these decisions seemingly exacerbates these differences.

Evaluation outcomes were often limited by subjectivity, reliance on proximal (i.e. attendance rates) and distal outcomes (i.e. referrals to specialist services). Longer-term outcomes were desirable but beyond reach. Selecting outcomes was deemed challenging and as previously acknowledged, whilst proximal training outcomes may be more reliable they can fail to identify how training can impact upon practice, and conversely, distal

outcomes may be influenced by unknown confounding factors and take time to come to fruition[14]. This, along with the pragmatic complexities of conducting 'ideal' evaluations, created a gap between outcomes deemed most useful and those actually measured.

Consistent with learning theory[15], PHPs agreed that relevance of training was essential to staff engagement. There was a consensus that engagement had increased due to policies such as the NHS' 5-year forward view[6]. Despite this, strong advocates are needed to maintain this momentum and avoid programmes being decommissioned. As funding cuts jeopardised existing training programmes, participants recognised the need to embed MECC within their organisational culture and introduce some standardisation to staff training, based on the best available evidence-based practice.

What is already known on this topic

Supporting health behaviour change with individuals can lead to improvements in health inequalities, national disease burden, and NHS costs[1-3]. MECC has attracted attention as a way to promote opportunities to have these conversations with individuals and it is now expected that MECC is implemented across NHS England and partner organisations[6,7].

What this study adds

NHS trusts and local authority organisations are interpreting MECC differently and facing difficulties in selecting how best to focus or evaluate staff training. For MECC to be implemented successfully, future research should be directed towards strengthening the evidence base underpinning staff training, including clarifying whether it should be narrow or broad in topic, delivered online or face-to-face, or is mandatory or voluntary. Research is also needed to identify feasible methods for measuring meaningful outcomes. Finally, this study highlights that despite growing engagement in the MECC approach, training programmes may be unsustainable if contextual barriers such as organisational culture and resourcing issues are not addressed.

Limitations of this study

Although in line with qualitative principles[13], findings from this small sample cannot be generalised to all PHPs involved in MECC within the UK. Findings could be biased by

including individuals with increased interest in discussing their experiences of MECC. However, the variation in sample characteristics including the organisation region, size and setting, and current MECC status within that organisation mitigates this. Nevertheless the challenges identified may underestimate those of other organisations or PHPs.

Conclusion

A number of factors need to be in place in order for MECC to be implemented successfully: (i) consistent high quality training programmes (which are evidence based and relevant to the needs of the trainee), (ii) meaningful and feasible ways of evaluating MECC and providing feedback to staff, (iii) engaged organisations to support and promote MECC in a sustainable way.

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Table 1. Interview Topic Guide

1. In what ways are you currently involved in the implementation of MECC behaviour change training? a. How are you involved in the design of this training? b. How are you involved in the delivery of this training?
2. Please can you describe the MECC behaviour change training you are currently involved in? a. Online/face-to-face b. What content does it involve? c. How long is it? d. How were the decisions about what to include in the training made?
3. How successful do you feel current MECC behaviour change training is for the Trust that you work within? a. What about across the UK? b. What would improve the MECC behaviour change training you currently are involved in? c. How do you feel your training compares to training from other UK Trusts?
4. What do you feel are the main aims of MECC? a. To what extent does the Trust you work within fulfil this aim?
5. What feedback have you had so far about the MECC behaviour change training you are involved in? a. Positive b. Negative
6. How could / should MECC behaviour change training be evaluated? a. What would determine its success? b. What discussions have you had previously about how to best evaluate this training?
7. How likely are you and others involved in MECC training to want to be involved in a trial to evaluate this training? a. Why? b. What would make you/others more likely to want to be involved? c. What would make you/others less likely to want to be involved?
8. How able are you and others involved in MECC to be involved in a trial to evaluate this training? a. Why? b. What would make you/others more able to be involved? c. What would make you/others less able to be involved?
9. How ready are you and others involved in MECC to be involved in a trial to evaluate this training? a. Why? b. What would make you/others more ready to be involved? c. What would make you/others less ready to be involved?
10. Do you have any other thoughts about MECC implementation or evaluation that we haven't covered?

Table 2. Characteristics of participants interviewed (n=13).

Participant characteristic	**Frequency**
Job Type*	
Public Health Specialist *(Registrars/Consultants)*	3
Trust Director *(incl. Associate or Assistant Directors)*	4
Health Promotion Programme Manager *(designs and/or delivers programme)*	6
Organisation Setting	
Hospital Trust	6
Community Trust	3
Local Authority	4
Organisation Regions	
North West England	4
North East England	3
East Midlands	3
South West England	1
South East England	2
Staff Capacity Within Organisation *(i.e. Trust/ Local Authority)*	
Small (≤5,000)	5
Medium (5,001-10,000)	4
Large (>10,000)	4
MECC Status *(is MECC currently being implemented within the organisation?)*	
Yes	6
No	3
In planning	4

**All participants had direct responsibility for the either the design, development, evaluation or implementation of MECC within their organisation.*